

**FORNEBUKLINIKKEN AS**

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**Health information**

The information about your health will help us evaluate whether it is safe to perform the operation.

Please fill in the form as accurately as you can. **If you answer "yes" to any of the questions below, please use the back of the form to provide more detailed information.**

Submitting this form involves no form of commitment on your part. The information will be stored in a secure place and destroyed if you decide not to go through with the operation.

First name: \_\_\_\_\_  
 Last name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Postal code: \_\_\_\_\_  
 Town/City: \_\_\_\_\_  
 Phone (daytime): \_\_\_\_\_  
 Cell phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 E-mail: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

	Yes	No
Have you been to our clinic before – for surgery? Year: _____		
Have your been to our clinic before – for a consultation? Year: _____		
<b>Do you or have you suffered from any of these conditions?</b>		
Heart attack / angina		
Irregular pulse		
Other heart conditions		
High blood pressure		
Thrombosis / phlebitis		
Swollen ancles		
Asthma / bronchitis		
Sleep apnea		
Other lung diseases		
Liver disease / jaundice		
Smoking, if yes, how many a day: .....		
Daily intake of alcohol		
Metabolic diseases / diabetes		
Eye diseases		
Hereditary diseases		
Allergy		
Abnormal reaction to medicines		
Abnormal wound healing		
Do Abnormal bleeding, for instance during labor or from small cuts?		

	Yes	No
Are you susceptible to infections in wounds?		
Paralysis / muscular atrophy		
Serious back ailments / diseases of the joints		
Neck problems / neck injury		
Epilepsy (falling sickness) / tendencies to faint		
Mental problems		
Kidney disease / urinary tract diseases		
Gastric ulcer / intestinal diseases		
Eating disorders		
Other diseases / health problems		
Regular need of medications (if YES, use the back of the sheet for more information)		
Occational use of medications (if YES, use the back of the sheet for more information)		
Height: ..... cm Weight: .....kg		
Former operations		
Hospitalizations		
Former anaesthesia or epidural		
Do you feel healthy and in good shape?		
Local anaesthesia – any abnormal reactions or lack of effect?		

I declare that the information I have provided in this form is as accurate and extensive as possible, and that I will follow the advice and instructions given by the clinic both before and after an operation.

\_\_\_\_\_

DATE      SIGNATURE (can wait until you have decided on surgery)